

SUBCHAPTER 7. STANDING ORDERS FOR ADULT PATIENT

Adopted 08/2011

Update 03/2013

8:41-7.1 Scope

The following treatment protocols shall be considered standing orders when treating adult patients. For the purpose of this subchapter, adult patients are defined as those persons who have attained the age of 13 years or older (that is, from the date of the person's thirteenth birthday and beyond).

8:41-7.2 Applicability and restrictions

(a) The standing orders set forth in this subchapter shall be adopted in their entirety by the provider's medical director with the exception of the standing order for cyanide poisoning and standing order for nerve agent poisoning, after notification to OEMS. Except where specifically noted, these standing orders shall not be altered, abbreviated, or enhanced in any manner.

(b) The standing orders contained in this subchapter are initial treatment protocols that may be utilized by ALS crewmembers. These protocols apply only to adult patients, and may be implemented prior to contact with medical command. In the event the implementation of these standing orders is delayed for any reason, the medical command physician shall be contacted immediately following the delay.

(c) Any situation other than those specifically identified in this subchapter requires the ALS crewmembers to contact medical command before providing any ALS treatment.

(d) These standing orders shall not be interpreted as a requirement to administer ALS treatment prior to contact with medical command. ALS crewmembers may elect to contact medical command at any time during the provision of therapy. Unless otherwise provided in these rules, standing orders cease to be operative once contact is made with medical command.

(e) The standing orders contained in this subchapter shall not be considered to represent total patient management. Contact with medical command shall be established at the point indicated in the standing order, unless established sooner in accordance with (d) above. At no time shall communications with medical command be delayed due to difficulty in intubating the patient and/or initiating an IV line.

(f) The presence of an allergy to any medication or therapeutic agent set forth in these standing orders shall be deemed to be a contraindication to the administration of that medication or therapeutic agent. In such instances, the medication or therapeutic agent shall not be administered.

(g) Each case utilizing these standing orders shall be fully documented on the patient care report. The provider's quality assurance plan shall include provisions for review of calls where standing orders are utilized, in accordance with the standards set. Cases that do not follow the standing orders as set forth in this chapter or where contact is never made with medical command shall be forwarded to the medical director for a mandatory review.

8:41-7.3 Standing orders for Advanced Airway Management

(a) The following standing orders are authorized in the event that an adult patient presents:

1. In respiratory arrest;
2. In respiratory failure with associated inadequate spontaneous ventilatory volume; and/or
3. Unconscious with absent protective gag reflex.

(b) In the event that a patient presents as above, the ALS crewmembers may perform advanced airway insertion to include intubation or insertion of a supraglottic airway;

(c) Advanced interventions shall only be attempted after all BLS interventions have been instituted.

1. In the event of a suspected tension pneumothorax, where the patient presents with progressive severe respiratory distress with cyanosis, hypoxia as defined by a pulse oximetry reading of 90% or less with a non-rebreather mask in place at 12-15 lpm or intubated, diminished or absent breath sounds on the affected side, and hypotension as defined as a systolic blood pressure less than 90 mmHg, perform a needle chest decompression;

(d) If patient exhibits signs and symptoms of gastric distension that compromises ventilation or circulation, and an advanced airway is in place, the ALS crewmember may place a naso/orogastric tube to relieve the gastric distention or pressure in an effort to reduce the risk of aspiration and increase the intrathoracic volume.

(e) It is imperative that the ALS crewmembers initiate contact with medical command as soon as possible after the above treatment has been rendered. These procedures shall not delay the transportation of a patient in the event of a difficult intubation, nor shall contact with medical command be delayed by a difficult airway.

(f) This standing order may be utilized in conjunction with any other standing order where the patient's airway needs to be secured.

8:41-7.4 Standing orders for Vascular Access

(a) The following standing orders for the initiation of vascular access are authorized in those cases where an emergent or potentially emergent condition exists and current ALS treatment protocols require the initiation of vascular access. In such cases, ALS crewmembers may establish vascular access at keep vein open (KVO) rate or with a saline port prior to contacting medical command.

- i. if IO access is achieved on a conscious patient, ALS may administer 40mg of Lidocaine prior to fluid infusion.

- ii. If IV/IO access is not available or unsuccessful the patient's Established Vascular Access Device (EVAD) may be accessed if one of the following emergent conditions is present:
 - 1. Cardiac Arrest
 - 2. Unstable patient with systolic blood pressure less than 90 mmHg with signs of shock (chest pain, cardiac arrhythmia, altered mental status, significant dyspnea, anaphylaxis)
- iii. EVAD is defined as an established central venous catheters and/or subcutaneous indwelling catheters

(b) ALS crewmembers shall contact medical command as soon as possible after the establishment of vascular access. Contact with medical command shall not be delayed by, or as a result of, unsuccessful vascular access in the field.

(c) The time of the initiation of vascular access and the time of contact with medical command shall be recorded on the patient care report.

(d) This standing order may be utilized in conjunction with any other standing order where vascular access is indicated.

8.41-7.5 Standing orders for Ventricular Fibrillation and Pulseless Ventricular Tachycardia

(a) The following standing orders are authorized in the event that an adult patient presents with cardiac arrest with the rhythm determined to be ventricular fibrillation or pulseless ventricular tachycardia:

1. If the patient is not a witnessed arrest, initiate CPR.
2. If CPR has been started by a first responder or is a witnessed arrest by ALS crewmember(s), immediately review the cardiac rhythm. If indicated defibrillate at 360 joules or manufacturer's suggested biphasic equivalent and immediately resume CPR;
3. During CPR;
 - i. Assess and secure airway. Once an advanced airway has been established, perform continuous compressions at a rate of at least 100 per minute while giving ventilations at a rate of 8 to 10 times per minute, for 2-minute cycles.
 - ii. Establish vascular access and administer 500 mL normal saline via vascular access;
 - iii. Administer Epinephrine 1 mg 1:10,000 via vascular access or 2 mg 1:10,000 through the endotracheal tube. May be repeated every three to five minutes while continuing protocol, or administer Vasopressin 40 units via vascular access one time only and continue CPR;

4. Reassess the cardiac rhythm every two minutes, if rhythm remains ventricular fibrillation or pulseless ventricular tachycardia, defibrillate at 360 joules or manufacturer's suggested biphasic equivalent and immediately resume CPR;

- i. If at any point the patient has return of spontaneous circulation and has not been given any anti-dysrhythmic medication, then administer Amiodarone 150 mg over 10 minutes via vascular access and go to step 6;

5. Administer 300 mg Amiodarone or 1.5mg/kg of Lidocaine via vascular access and continue CPR. If rhythm remains ventricular fibrillation or pulseless ventricular tachycardia, administer 150 mg Amiodarone or 1.5 mg/kg of Lidocaine via vascular access in 3 to 5 minutes from the first dose, and continue CPR;

6. Contact the medical command.

(b) Should ventricular fibrillation or pulseless ventricular tachycardia recur after contact is made with medical command, an ALS crewmember may follow step 2 through 4 until medical command can be re-established.

(c) Follow each medication given via vascular access with a 20 mL fluid bolus;

(d) Total amount of solutions given via ET not to exceed 50 mL;

(e) Any treatments related to this protocol administered prior to ALS arrival should be considered as part of this standing order.

8:41-7.6 Standing orders for Asystole/PEA

(a) The following standing orders are authorized in the event that an adult patient presents with cardiac arrest with the rhythm determined to be asystole or PEA:

1. Initiate or continue CPR;

- i. If asystole confirm in a second lead;

2. During CPR;

- i. Assess and secure airway. Once an advanced airway has been established, perform continuous compressions at a rate of at least 100 per minute while giving ventilations at a rate of 8 to 10 times per minute, for 2-minute cycles.
- ii. Establish vascular access and administer 500 mL normal saline via vascular access;
- iii. Administer Epinephrine 1 mg 1:10,000 via vascular access or 2 mg 1:10,000 through the endotracheal tube. May be repeated every three to five minutes while continuing protocol, or administer Vasopressin 40 units via vascular access one time only and continue CPR;

3. Search for reversible causes;
 - i. If the blood glucose test indicates a level less than 60 mg/dl, administer 25 g of 50 percent Dextrose in water intravenously. If unable to establish vascular access, administer 1 mg Glucagon intramuscularly;
 - ii. If suspected opiate overdose administer Naloxone 2 mg through an approved route of administration;
4. Reassess the cardiac rhythm every two minutes; and
 - i. If cardiac rhythm ventricular fibrillation or pulseless ventricular tachycardia follow standing orders for ventricular fibrillation/ pulseless ventricular tachycardia as outlined in N.J.A.C. 8:41-7.5.
5. Contact the medical command.

(b) Consider termination of efforts only with the input of the medical command physician if asystole/agonal rhythms continue after successful advanced airway placement and initial medications. The time interval since arrest shall also be considered.

(c) Follow each medication given via vascular access with a 20 mL fluid bolus;

(d) Total amount of solutions given via ET not to exceed 50 mL.

8:41-7.7 Standing orders for burn management

(a) The following standing orders are authorized in the event that a patient presents with burns:

1. Stop the burning process;
2. If hazardous materials are suspected, take proper precautions and contact medical command physician for guidance on treatment protocols;
3. Immobilize the spine if indicated;
4. Assess and secure the airway;
 - i. If evidence of trauma, refer to N.J.A.C. 8:41-7.8, *Standing orders for trauma*;
5. Consider endotracheal intubation if indicated for airway burns and/or respiratory compromise;
6. Administer oxygen therapy as patient condition indicates;
7. Cover the burns with a dry dressing or sheet;

8. Maintain normal body temperature;
9. Begin transportation of patient to the most appropriate facility;
10. Establish vascular access;
11. ALS crewmember may administer up to 1 liter normal saline or Lactated Ringer's based on patient presentation;
12. If patient's systolic blood pressure is at least 90 mmHg, administer Morphine Sulfate 0.1mg/kg up to 10 mg or Fentanyl 1mcg/kg up to 100 mcg, titrated slowly; and
13. Contact medical command.

8:41-7.8 Standing orders for trauma

(a) The following standing orders are authorized in the event that an adult patient presents with a traumatic injury:

1. Provide basic life support as necessary;
2. Assess and secure airway;
3. Provide spinal precautions if indicated;
4. Administer oxygen therapy as patient condition indicates;
 - i. In the event of a suspected tension pneumothorax, where the patient presents with progressive severe respiratory distress with cyanosis, hypoxia as defined by a pulse oximetry reading of 90% or less with a non-rebreather mask in place at 12-15 lpm or intubated, diminished or absent breath sounds on the affected side, and hypotension as defined as a systolic blood pressure less than 90 mmHg, perform a needle chest decompression;
5. Transport the patient as soon as possible to the most appropriate facility according to the National Trauma Triage Protocols; transportation shall not be delayed due to difficulty in placing an advanced airway and/or establishing vascular access, except at the specific direction of the medical command;
6. Establish vascular access using Lactated Ringer's solution or normal saline solution with two large bore catheters. Titrate the fluid administration rate to maintain a systolic blood pressure of greater than 90 mmHg and a pulse rate of less than 120 per minute, to a maximum dose of one liter;
7. If patient's systolic blood pressure is at least 90 mmHg, ALS crewmember may administer Morphine Sulfate 0.1mg/kg up to 10 mg or Fentanyl 1mcg/kg up to 100 mcg for pain management, titrated slowly; and

8. Contact medical command.

8:41-7.9 Standing orders for bradycardia

(a) The following standing orders are authorized in the event that an adult patient presents with bradycardia (heart rate less than 60 beats per minute) in which the patient displays hypotension, shock or other significant symptoms consistent with hemodynamic instability:

1. Assess and secure airway;
2. Obtain 12 lead electrocardiogram;
3. Establish vascular access;
 - i. If vascular access cannot be established, proceed directly to transcutaneous pacing;
4. If the patient does not have signs or symptoms of an acute myocardial infarction, administer Atropine Sulfate 0.5 mg via vascular access; May be repeated every three to five minutes to a maximum of 3 mg;
 - i. Note: Denervated hearts (ie. heart transplants) and patients with high degree heart blocks will not respond to Atropine Sulfate. In such cases, initiate external cardiac pacing.
5. If there is no response to the Atropine Sulfate or the patient is having signs or symptoms of an acute myocardial infarction, administer transcutaneous pacing at a rate of 70, at the lowest amount of energy necessary to obtain capture; and
6. Contact medical command.

(b) In stable patients with Type II second degree or third degree AV block, transcutaneous pacemaker pads should be applied as a precaution.

8:41-7.10 Standing orders for pulmonary edema/congestive heart failure

(a) The following standing orders are authorized in the event that an adult patient presents with pulmonary edema/congestive heart failure:

1. Assess and secure airway;
2. Administer oxygen therapy as patient condition indicates;

3. Administer 0.4 mg Nitroglycerin sublingually every five minutes, provided the systolic blood pressure is greater than or equal to 100 mmHg;
4. Obtain 12-lead electrocardiogram tracing;
 - i. If patient presents with chest pain or electrocardiogram suggests an acute myocardial infarction, ALS crewmember may administer Acetylsalicylic Acid by mouth to make the total dose received by the patient to a maximum dose of 324 mg; this includes any aspirin already taken by the patient prior to ALS encounter;
5. Establish vascular access;
6. Administer Furosemide 20 mg or Bumetanide 0.5 mg via vascular access; and
7. Contact medical command.

8:41-7.11 Standing orders for suspected acute myocardial infarction/chest pain

(a) The following standing orders are authorized in the event that an adult patient presents with acute myocardial infarction/chest pain:

1. Assess and secure airway;
2. Administer oxygen therapy as patient condition indicates;
3. Administer Acetylsalicylic Acid by mouth to make the total dose received by the patient to a maximum dose of 324 mg; this includes any aspirin already taken by the patient prior to ALS encounter;
4. Obtain 12-lead electrocardiogram tracing;
5. Administer 0.4 mg Nitroglycerin sublingually every 5 minutes provided the systolic blood pressure is greater than or equal to 100 mmHg;
6. Establish vascular access;
7. If the patient is having an acute myocardial infarction, review patient's eligibility for thrombolytic therapy as determined by the provider's Medical Director, and follow the New Jersey Department of Health and Senior Services' STEMI Triage Guidelines;
8. Contact medical command.

(b) The sequence of actions 2 to 6 above may be performed simultaneously and does not need to be in specific order.

8.41-7.12 Standing orders for sustained stable wide-complex tachycardia

(a) The following standing orders are authorized in the event that an adult patient presents with a stable wide-complex tachycardia:

1. Assess and secure airway;
2. Establish vascular access;
3. Obtain 12-lead electrocardiogram tracing;
4. Continue to assess the patient and monitor the cardiac rhythm;
5. If sustained wide-complex tachycardia, administer Amiodarone 150 mg over 10 minutes or 1.5mg/kg of Lidocaine via vascular access; and
6. Contact the medical command.

8.41-7.13 Standing orders for unstable wide-complex tachycardia

(a) The following standing orders are authorized in the event that an adult patient presents with an unstable wide-complex tachycardia where the patient is unconscious or hemodynamically compromised:

1. Assess and secure airway;
2. Establish vascular access;
3. If the patient is conscious, consider sedation with Lorazepam 0.05 mg/kg up to a maximum of 2 mg or Midazolam 0.05 mg/kg up to a maximum dose of 5 mg, based on patient's clinical presentation and administer if appropriate;
4. Perform a synchronized cardioversion at 100 joules or manufacturer's recommended biphasic equivalent. Check the patient's pulse and cardiac rhythm after the shock;
 - i. If the rhythm fails to convert, perform a synchronized cardioversion at 200 joules or manufacturer's recommended biphasic equivalent. Check the patient's pulse and cardiac rhythm after the shock;
 - ii. If the rhythm fails to convert, perform a synchronized cardioversion at 300 joules or manufacturer's recommended biphasic equivalent. Check the patient's pulse and cardiac rhythm after the shock;
 - iii. If the rhythm fails to convert, perform a synchronized cardioversion at 360 joules or manufacturer's recommended biphasic equivalent. Check the patient's pulse and cardiac rhythm after the shock;
5. If the rhythm is converted at any point, administer Amiodarone 150 mg over 10 minutes or 1.5mg/kg of Lidocaine via vascular access;

6. Contact the medical command.

(b) If the patient deteriorates into VF/Pulseless VT, deliver high-energy *unsynchronized* shock [i.e., defibrillation dose] at 360 J or manufacturer's recommended equivalent biphasic and follow standing orders for ventricular fibrillation/ pulseless ventricular tachycardia as outlined in N.J.A.C. 8:41-7.5.

(c) If a patient has polymorphic VT and is unstable, treat the rhythm as ventricular fibrillation and deliver high-energy *unsynchronized* shocks [i.e., defibrillation doses] at 360 J or manufacturer's recommended equivalent biphasic. If there is any doubt whether monomorphic or polymorphic VT is present in the unstable patient, do not delay shock delivery to perform detailed rhythm analysis – provide high-energy unsynchronized shocks (ie. Defibrillation doses).

8:41-7.14 Standing orders for stable narrow complex tachycardia

(a) The following standing orders are authorized in the event that an adult patient presents with a stable narrow complex tachycardia:

1. Assess and secure airway;
2. Establish vascular access (IV, in the antecubital fossa, if possible);
3. Perform a patient assessment, including medical history and allergies;
4. Perform a 12-lead electrocardiogram tracing and continue to assess the patient and monitor the cardiac rhythm;
 - i. If Wolff-Parkinson-White is identified go to step 10.
 - ii. If atrial fibrillation or atrial flutter is identified at any time, and no Wolff-Parkinson-White is known or suspected, administer Diltiazem 0.25mg/kg IV over 2 minutes and go to step 10.
5. Attempt vagal maneuver;
6. Administer 6 mg Adenosine rapid push via vascular access over a period of one to three seconds, followed by a 20 mL bolus of normal saline solution rapid push via vascular access;
7. If there is no conversion with 6 mg Adenosine, then administer 12 mg Adenosine rapid push via vascular access followed by a 20 mL bolus of normal saline solution rapid push via vascular access;
8. If there is no conversion with 12 mg Adenosine, then repeat administration of 12 mg Adenosine rapid push via vascular access followed by a 20 mL bolus of normal saline solution rapid push via vascular access;

9. If there is no conversion with the third dose of Adenosine and no Wolff-Parkinson-White is known or suspected then administer Diltiazem 0.25mg/kg over 2 minutes via vascular access, and;
10. Contact medical command.

8:41-7.15 Standing orders for unstable narrow complex tachycardia

(a) The following standing orders are authorized in the event that an adult patient presents with an unstable narrow complex tachycardia:

1. Assess and secure airway;
 - i. If Wolff-Parkinson-White is identified go to step 7;
2. Establish vascular access (IV in the antecubital fossa, if possible);
3. If patient is unconscious go to step 6;
4. If the patient is conscious and vascular access has been established, and the rhythm is regular; administer Adenosine 6 mg rapid push via vascular access, followed by 20 mL fluid bolus rapid push via vascular access;
 - i. If the patient becomes unconscious go to Step 6;
 - ii. If the patient converts and is conscious go to Step 7;
5. If there is no conversion and the patient is still conscious administer Adenosine 12 mg rapid push via vascular access, followed by 20 mL fluid bolus rapid push via vascular access;
 - i. If there is no conversion with the 12 mg Adenosine and the patient is conscious ALS crewmember may administer if appropriate either Lorazepam 0.05 mg/kg up to a maximum of 2 mg or Midazolam 0.05 mg/kg up to a maximum of 5mg through an approved route of administration;
6. Perform a synchronized cardioversion at 50 joules or manufacturer's recommended biphasic equivalent. If rhythm is atrial fibrillation go to 6ii. Check the patient's pulse and cardiac rhythm after the shock;
 - i. If the rhythm fails to convert, perform a synchronized cardioversion at 100 joules or manufacturer's recommended biphasic equivalent. Check the patient's pulse and cardiac rhythm after the shock;
 - ii. If the rhythm fails to convert, perform a synchronized cardioversion at 200 joules or manufacturer's recommended biphasic equivalent. Check the patient's pulse and cardiac rhythm after the shock;

- iii. If the rhythm fails to convert, perform a synchronized cardioversion at 300 joules or manufacturer's recommended biphasic equivalent. Check the patient's pulse and cardiac rhythm after the shock;
- iv. If the rhythm fails to convert, perform a synchronized cardioversion at 360 joules or manufacturer's recommended biphasic equivalent. Check the patient's pulse and cardiac rhythm after the shock; and

7. Contact the medical command.

(b) If the patient deteriorates into VF/Pulseless VT, deliver high-energy *unsynchronized* shock [i.e., defibrillation dose] at 360 J or manufacturer's recommended equivalent biphasic and follow standing orders for ventricular fibrillation/ pulseless ventricular tachycardia as outlined in N.J.A.C. 8:41-7.5.

8:41-7.16 Standing orders for allergic reaction/anaphylactic shock

(a) The following standing orders are authorized in the event that an adult patient presents with signs of generalized allergic findings such as urticaria without signs of acute significant respiratory distress and/or profound hypotension (systolic blood pressure less than or equal to 90 mmHg)

1. Assess and secure airway;
2. Administer oxygen therapy as patient condition indicates;
3. Establish vascular access
4. Administer 50 mg Diphenhydramine HCL via vascular access;
5. Contact medical command.

(b) The following standing orders are authorized in the event that an adult patient presents with signs of generalized allergic findings such as urticaria with signs of acute significant respiratory distress and /or profound hypotension, (systolic blood pressure less than or equal to 90mmHg) with clinical evidence of shock, (altered mental status; cool clammy or mottled skin; and /or delayed capillary refill).

1. Assess and secure airway;
2. Administer oxygen therapy as patient condition indicates;
3. Administer 0.3mg Epinephrine 1:1000 IM in lateral thigh or deltoid;
4. If wheezing is present, administer 2.5mg Albuterol/3 mL normal saline solution via nebulizer; which may be repeated up to three times at the same dose;

5. Establish vascular access and administer 500 mL fluid bolus. The bolus should be repeated up to one liter if blood pressure remains less than 100 systolic and the patient is not exhibiting new signs of pulmonary edema;
6. Administer Diphenhydramine HCL 50mg via vascular access;
7. Administer Methylprednisolone Sodium Succinate 125 mg or Dexamethasone Sodium Phosphate 10 mg via vascular access; and
8. Contact medical command.

8:41-7.17 Standing orders for respiratory distress with wheezing due to COPD or bronchoconstriction

(a) The following standing orders are authorized in the event that an adult patient presents with dyspnea where the signs and symptoms are consistent with asthma, COPD or any other dyspnea associated with wheezing or suspected bronchospasm:

1. Assess and secure airway; administer oxygen as needed, or via nebulizer;
2. Mix 2.5 mg Albuterol and Ipratropium Bromide 0.5 mg into normal saline and administer via nebulizer;
3. Establish vascular access;
4. Reassess patient and if patient condition requires administer a maximum of two additional treatments of 2.5 mg Albuterol/3 mL normal saline solution via nebulizer;
 - i. If patient presents with signs and symptoms of pulmonary edema/congestive follow standing orders for pulmonary edema/congestive heart failure as outlined in N.J.A.C. 8:41-7.10.
5. Contact medical command.

8:41-7.18 Standing orders for unconscious person/altered mental status

(a) The following standing orders are authorized in the event that an adult patient is unconscious or presents with altered mental status. The treatment of an unconscious person/altered mental status patient shall be directed by the suspected etiology of the event. Specific orders may be omitted by an ALS crewmember if the order does not pertain to the suspected etiology of the medical emergency:

1. Assess and secure airway;
2. Evaluate blood glucose. If etiology suggests possible stroke follow the New Jersey Department of Health and Senior Services' Stroke Triage Guidelines.

3. Establish vascular access;
4. Assess blood glucose, if blood glucose is less than 60mg/dl;
 - i. Administer up to 25 gms Dextrose in water;
 - (1) If unable to administer Dextrose, administer 1 mg Glucagon intramuscularly; and
 - ii. ALS crewmember may administer 100 mg Thiamine IV/IO if appropriate;
 - iii. If there is no response to (a)4i and ii above, or if the blood glucose level is greater than 60 mg/dl, administer up to 2 mg Naloxone through an approved route of administration. Start with 0.4 mg and titrate the dose to reversal of any respiratory depression; and
6. Contact medical command.

8:41-7.19 Standing orders for nontraumatic hypotension

(a) The following standing orders are authorized in the event that an adult patient presents with significant and symptomatic hypotension (systolic blood pressure less than 90 mmHg) unaccompanied by bradycardia or trauma, with patient exhibiting signs of shock due to dehydration, sepsis, and nontraumatic hemorrhage (for example, gastrointestinal bleeding):

1. Assess and secure airway;
2. Establish vascular access, and administer a 500 mL bolus of IV solution;
3. Reassess vital signs and the condition of the patient; and
4. Contact medical command.

8:41-7.20 Standing orders for active seizures

(a) The following standing orders are authorized in the event that an adult patient presents with active seizures:

1. Assess and secure airway;
2. Establish vascular access;
3. If ALS witnesses the patient actively having a generalized seizure for 2 minutes or greater or having repetitive seizures, then administer through an approved route of administration either;

- a. Lorazepam 2mg or;
- b. Diazepam 5mg or;
- c. Midazolam 5mg.

5. Assess blood glucose, if blood glucose is less than 60mg/dl; administer 25 g of 50 percent Dextrose in water intravenously;

- i. If unable to establish vascular access, administer 1 mg Glucagon intramuscularly; and

6. Contact medical command

8:41-7.21 Standing orders for cyanide poisoning

(optional, at medical director's discretion)

(a) The following standing orders (optional, at the medical director's discretion) are authorized in the event that an adult patient presents with cyanide poisoning:

1. Do not enter or attempt to rescue a person in an area suspected or documented to be contaminated with cyanide poison;

2. Before making patient contact, ensure that appropriate decontamination has been performed;

- i. If the patient has been exposed to liquid cyanide, ensure that all of the patient's clothing has been removed;

- ii. No decontamination is needed for pure vapor exposure;

3. Determine the level of exposure;

- i. If the level of exposure is mild (that is, the patient is conscious and breathing):

(1) Assess and secure the airway;

(2) Administer high concentration oxygen; and

(3) Observe the patient for respiratory distress;

- ii. If the level of exposure is severe (that is, the patient is unconscious or if respirations are severely compromised):

(1) Assess and secure the airway;

(2) Administer high concentration oxygen;

(3) Provide suctioning (if necessary);

If using the CYANOKIT® skip to step 7;

(4) If Cyanide kit is available, break and hold an aspirol of Amyl Nitrite in front of the patient's nose for 30 seconds, followed by removal for 30 seconds; use a new aspirol of Amyl Nitrite approximately every three minutes thereafter until IV access has been established. If the patient is unconscious, place the aspirol of Amyl Nitrite in the mask of the bag-valve-mask device or in the bag-valve-mask device itself;

(5) Establish IV access;

(6) Administer Sodium Thiosulfate 12.5 grams IV over ten (10) minutes; and go to step 11,

(7) If CYANOKIT® is available, add 100 mL of 0.9% Sodium Chloride Injection to first CYANOKIT® vial using transfer spike;

(8) Mix CYANOKIT® vial for 30 seconds to mix solution. Do not shake;

(9) Use vented IV tubing to hang and infuse first vial over 10 minutes;

(10) Repeat steps 7 through 9 for second vial of CYANOKIT®; and

(11) Contact medical command.

8:41-7.22 Standing orders for nerve agent poisoning (optional, at medical director's discretion)

(a) The following standing orders (optional, at medical director's discretion) are authorized in the event that an adult patient presents with nerve agent poisoning:

1. Do not enter or attempt to rescue a person in an area suspected or documented to be contaminated with nerve agent poison;
2. Before making patient contact, ensure that appropriate decontamination has been performed. No decontamination is need for pure vapor exposure;
3. Assess the patient for signs of nerve agent toxicity (SLUDGEM);

i. SLUDGEM stands for:

- (1) Salivation (excessive production of saliva);
- (2) Lacrimation (excessive production of tears);
- (3) Urination (uncontrolled urine production);
- (4) Defecation (uncontrolled bowel movements);
- (5) Gastrointestinal distress (cramps, hyperactive bowel sounds);
- (6) Emesis (excessive vomiting); and

(7) Miosis (constricted pupils)

4. Determine the level of exposure;

i. If the level of exposure is mild (that is, the patient is conscious and breathing):

- (1) Assess and secure the airway;
- (2) Administer high concentration oxygen;
- (3) Observe the patient for respiratory distress; and
- (4) Establish vascular access;

ii. If the level of exposure is severe (that is, the patient is unconscious or if respirations are severely compromised):

- (1) Assess and secure the airway;
- (2) Administer high concentration oxygen;
- (3) Establish vascular access;
- (4) Administer Atropine 2 mg IV; and
- (5) Administer Pralidoxime Chloride 1 gram IV;

iii. If unable to establish vascular access, administer nerve agent auto injectors (Atropine 2 mg and Pralidoxime Chloride 600 mg) intramuscularly; and

5. Contact medical command.